



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ANGELA A SHIPPY, MD
3100 TIMMONS LANE, STE 250
HOUSTON, TEXAS 77027

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-11-0494-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CARRIER failed to reimburse for claim even after a request for reconsideration was sent back to carrier."

Amount in Dispute: \$150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "1. The requestor determined MMI on 6/25/10. The IR was 0%. 2. Texas Mutual paid \$350.00 for the MMI exam. 3. The requestor used the DRE method to arrive at the IR. Texas Mutual paid \$150.00 for this... Texas Mutual paid a total of \$500.00 for the MMI/IR exams and believes no additional payment is due."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Hwy 290, Austin, Texas 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 25, 2010	99456-W5-WP	\$150.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated August 6, 2010

- CAC-W1 - WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
- 790 – THIS CHARGE WAS REIMBURSED IN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE.

Explanation of benefits dated September 3, 2010

- CAC-W1 - WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
- 790 – THIS CHARGE WAS REIMBURSED IN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE.

Issues

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to additional reimbursement for disputed services under 28 Texas Administrative Code §134.204?

Findings

1. The provider billed the amount of \$650.00 for CPT code 99456-W5-WP for a DD examination for Maximum Medical Improvement/Impairment Rating (MMI/IR). Review of the documentation supports that MMI was assigned and one body area was rated. Per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is \$350.00. Per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(I), the MAR for an IR using Diagnosis Related Estimates (DRE) Category I method on the thoracic (spinal region) is \$150.00. The combined MAR for the MMI/IR services rendered is \$500.00.
2. The respondent reimbursed the requestor \$500.00. Therefore, the requestor is not entitled to additional reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature


Signature _____ Gregory Fournierat _____ October 27, 2011
Medical Fee Dispute Resolution Officer Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.